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1st Session { { No. 98-19

CONSIDERATION OF MAJ. GEN. PAUL W. MYERS TO BE APPOINTED TO THE GRADE OF LIEUTENANT GENERAL ON THE RETIRED LIST

NOVEMBER 4 (legislative day, OCTOBER 31), 1983.—Ordered to be printed

Mr. TOWER, from the Committee on Armed Services, submitted the following

REPORT

The Committee on Armed Services, having had under consideration the nomination of Major General Paul W. Myers for appointment to the grade of lieutenant general on the retired list pursuant to the provisions of title 10, United States Code, section 1370, reports favorably thereon and recommends the nomination be confirmed.

SERVICE RECORD OF MAJ. GEN. PAUL W. MYERS

Date and place of birth: January 15, 1923, Schenectady, N.Y.
Years of active service: Over 36 years as of August 1, 1983.
Schools attended and degrees: Albany Medical College, MD, 1946; Aerospace Medicine, Primary, 1951.
Aeronautical rating: Flight surgeon.

Major permanent duty assignments	From—	To—
Enlisted status	July 43	27 June 45
Inactive status	28 Jan 49	27 Jun 49
Medical Officer, General, USAH, West Point, N.Y	1 Jul 49	Feb 50
Ch., Out Patient Department, 1141 Medical Service Squad Ft Myer, Va., with permanent duty station at USMA, West Point, N.Y	Feb 50	Apr 51
Deputy Air Surgeon, EADF, and later DS, Stu Off, AME Crs, Randolph AFB, TX and later Ch., Prof. Service Division, Air Surgeon, EAIF, Stewart AFB, N.Y.	Apr 51	Jun 52
Stu., Residency (Surgery) Ellis Hospital, Schenectady, N.Y. and later Residency (Neuro-Surgery) Albany Hospital, Albany, N.Y.; AFIT, Wright-Patterson AFB, OH	Jun 52	July 56
Neurosurgeon, 3275 and later 2349 USAF Hospital, Parks AFB, California	Jul 56	Jun 58
Ch., Neurosurgery Service, Wilford Hall USAF Hospital, Lackland AFB, TX	June 58	Apr 71
Commander, Wilford Hall USAF Medical Center, Lackland AFB, TX	Apr 71	Jul 78
Surgeon General of the AF, HQ USAF, Wash., D.C	Aug 78	Aug 82
Special Assistant to Vice Chief of Staff, Headquarters USAF, Washington, D.C. (reverted to Major General)	Oct 82	

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Promotions	Temporary	Permanent
First lieutenant		1 Jul 49
Captain	3 Jul 50	1 Mar 51
Major	11 Jun 54	3 Aug 56
Lieutenant colonel	13 Jun 60	1 Aug 62
Colonel	1 Nov 65	15 Sep 66
Brigadier general	1 Apr 72	24 Apr 74
Major general	12 Feb 75	24 Feb 78
Lieutenant general	1 Aug 78	
Major general	30 Oct 82	

Decorations and awards: Legion of Merit, Air Force Commendation Medal, Air Force Outstanding Unit Award with 1 Oak Leaf Cluster, Good Conduct Medal, National Defense Service Medal with 1 Bronze Service Star, Air Force Longevity Service Award Ribbon with 4 Oak Leaf Clusters, Miembro Honoris Causa de la Fuerza de Chile, Distinguished Service Medal (AF Design).

Background to Committee Action

The nomination of Major General Paul W. Myers, former Surgeon General of the Air Force, to retire in the grade of lieutenant general was first submitted to the Senate by the President on January 26, 1983. However, the Committee decided that this nomination deserved special attention because of certain prominent allegations about General Myers' performance during his tenure as Commanding Officer of Wilford Hall Medical Center in San Antonio, Texas. General Myers left this assignment to become Surgeon General of the Air Force in August 1978. These allegations generally relate to General Myers' actions when members of the medical staff at Wilford Hall questioned the competence of Colonel (Dr.) William Stanford, a leading Air Force cardiovascular surgeon also on the Wilford Hall staff. These allegations have been considered sufficiently serious to warrant two separate investigations, one by the Air Force Inspector General and one by the Office of the Secretary of Defense.

In considering General Myers' nomination, the Committee thoroughly reviewed the following: (1) background material on General Myers' entire service record; (2) the Air Force Inspector General's (IG) "Report of the Investigation of the Cardiothoracic Surgical Service, Wilford Hall, USAF Medical Center" (June 1983); (3) the Air Force IG's "Review and Evaluation of the Air Force Health Care System" (May 1982); (4) the "Report to the Secretary of Defense on the Review of Events Related to Wilford Hall, U.S. Air Force Medical Center" (December 30, 1982), an investigation directed by Dr. Theodore Cooper, consultant to the Secretary of Defense, and Mr. Joseph H. Sherick, the (then) Assistant to the Secretary of Defense (Review and Oversight); (5) the results of two formal mortality reviews of Dr. Stanford's surgical record requested by the Air Force in 1982, one conducted by a team of military surgeons under the leadership of Colonel (Dr.) Russ Zajtchuk, the Chief of Thoracic-Cardiovascular Surgery Service at Walter Reed Army Medical Center, the other conducted by a civilian professional group, the Society of Thoracic Surgeons; (6) a written statement submitted to the Committee by General Myers, which addresses the reports prepared by the Air Force IG and Dr. Cooper and Mr. Sherick; (7) rele-

vant portions of the court records in a civil law suit involving Dr. Stanford; (8) and other related documents and materials.

Chronology of Events

Based on the investigative reports reviewed by the Committee, the Committee believes that there is a general consensus concerning the following basic facts in this case.

The events generating the controversy concerning General Myers and Dr. Stanford took place at Wilford Hall Medical Center during the period of 1975 to 1977. Dr. Stanford was a cardiothoracic surgeon assigned to Wilford Hall from 1966 to 1980. He became Chief of the Thoracic Surgery Service in 1969. In July 1975, he was also designated to serve as Chairman of the Department of Surgery. Dr. Stanford retired from the Air Force on June 1, 1980. General Myers, a neurosurgeon, served at Wilford Hall from 1958 to 1978 in various assignments. He commanded the hospital from 1971 until August 1, 1978, when he was promoted to lieutenant general and appointed Surgeon General of the Air Force. General Myers has been succeeded as Surgeon General of the Air Force and is now serving as a special consultant to the Air Force Vice Chief of Staff. He reverted to his permanent grade of Major General on October 30, 1982.

During the period of 1975 through April 1977, some of the members of the professional staff at Wilford Hall developed serious concerns about the performance of Dr. Stanford as a cardiac surgeon. There were also concerns expressed about him as an administrator. Although there was some recognition given to Dr. Stanford's problems as an administrator, there was no action taken to investigate the concerns regarding his performance as a cardiac surgeon until the spring of 1977. In April and May of 1977, two military doctors, Dr. Cary W. Akins, a cardiothoracic surgeon, and Dr. John L. Waller, an anesthesiologist, took specific actions to bring their concerns about Dr. Stanford's surgical performance to the attention of General Myers, the Hospital Commander. In late April–early May 1977, Dr. Akins forwarded written data to General Myers through another physician alleging that Dr. Stanford had a surgical mortality rate of 45 percent, compared to 6 percent or less for the rest of the surgical staff. On May 26, 1977, Dr. Waller announced that he would not provide anesthesia services for two complex, high-risk pediatric cases to be performed by Dr. Stanford because of his concern about Dr. Stanford's skills as a cardiac surgeon.

General Myers Immediate Responses and the Ebert Report

As a result of these actions, General Myers, on June 1, 1977, placed limitations on certain categories of pediatric cardiothoracic surgery at Wilford Hall. After receiving an initial set of mortality statistics from Dr. Stanford on June 1, 1977, General Myers asked Dr. Stanford to provide him additional data. From June until September 1977, General Myers unsuccessfully attempted to reconcile the conflicting mortality statistics he had received from Dr. Akins, cardiologists on the hospital staff, and Dr. Stanford. In July 1977, he wrote Dr. Paul Ebert, the Air Force National Consultant for Cardiothoracic Surgery, to ask him to extend his forthcoming visit

to Wilford Hall in September in order to evaluate Dr. Stanford's surgical record.

Dr. Ebert visited Wilford Hall from September 19–21, 1977, and submitted his report to General Myers on September 28, 1977. After reporting that "the morale and enthusiasm of the cardiothoracic surgery staff seems to be excellent and the conduct of rounds and conferences are of high quality," Dr. Ebert addressed the questions raised about Dr. Stanford:

> * * * the question of one surgeon, Colonel William Stanford, having considerably worse operative results than other surgeons cannot be dismissed. In reviewing the deaths reported during the past year by Colonel Stanford, it is obvious that a high percent of these were very poor risk patients, ones in which the operative results would be of doubt in any center in which the procedures were performed. One could anticipate that when operating on many of the high risk/low yield infants with complexed congenital heart disease at limited facilities, one must question whether this is advisable. Thus, it would seem that the following recommendations would be applicable to define whether or not the question of competence of Colonel Stanford and the staff are comparable:
>
> (1) All attempts should be made for the next 6 to 12 months to obtain the lowest possible operative mortality. Thus, high risk patients with likelihood of mortality should not be operated upon during this period.
>
> (2) Complexed congenital heart lesions, such as infants with transposition complex, atrial ventricular canal, etc., should not be sent to surgery since their operative success is quite low in all people's hands.
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> (3) Patients selected for operation should be randomized among the full time staff. A prospective randomization over a 6 to 12 month period will serve the purpose of evaluating the results of each of the staff surgeons, either as the primary surgeon, or as the assistant surgeon at the time when the resident performs the case. This would eliminate the question of individual selection of high-risk patients and should alleviate criticisms. If a major discrepancy in operative results, i.e. mortality, is observed in the 6 to 12 month period, then some decision as to whether individuals with high operative mortality should continue to participate in the cardiac surgery portion of the service could be entertained.
>
> My overall opinion is that this is a high quality service, that with its limited capacity of space, facilities, etc., has attempted to undertake complex operative repairs on patients with very high risks. As well, many of the patients with advanced valve disease have had two or three previous operations and are in poor condition at the time of attempting operation. One would envision high mortality from this group and it was clear that the chief of service has undertaken a higher percent of these particular patients than other members of the staff. Thus, one will pre-

dict that a randomized approach to good risk patients would yield a very excellent operative mortality and clinical results.

My two major points, as seen from this visit, would be to obtain the best possible operative results over the next 12 month period by case selection, and to maintain the residency program in cardiothoracic surgery at all costs.

General Myers has subsequently stated that he felt Dr. Ebert's report resolved the concerns about Dr. Stanford. On October 6, 1977, General Myers forwarded the Ebert report to the Surgeon General of the Air Force, Lieutenant General George E. Schafer. General Schafer wrote the Air Force Vice Chief of Staff on November 9, 1977 that "We have received a clean bill of health."

THE TRAINING FELLOWSHIP AND THE LAWSUIT

During the early fall of 1977, General Myers agreed to Dr. Stanford's request to go on a six-month training fellowship with a private surgical association in Milwaukee, Wisconsin. This request was also approved by the Surgeon General of the Air Force at that time, General Schafer. General Myers has stated that he felt this fellowship would sharpen Dr. Stanford's surgical skills. Air Force officials at Wilford Hall did not inform that association of the allegations raised about Dr. Stanford's competence, nor was there any request for such information by that association.

During the otherwise apparently successful training fellowship, Dr. Stanford assisted in an operation during which a heart-lung machine was improperly connected to a patient, resulting in irreversible brain damage. In a subsequent lawsuit on behalf of the patient, a U.S. District Court in January 1982 found Dr. Stanford and others negligent and awarded damages of $2.2 million, of which the Government's liability (because of Dr. Stanford's military affiliation) was $1.8 million.

Dr. Stanford returned to Wilford Hall in August 1978. General Myers states that Dr. Stanford's surgical privileges were informally limited upon his return. Dr. Stanford continued on active duty until his retirement in June 1980.

THE AIR FORCE INSPECTOR GENERAL'S REPORT

In the fall of 1981, a number of articles about Dr. Stanford began to appear in the press as a result of the litigation going on in Milwaukee. In January 1982, the CBS news program "60 Minutes" broadcast a feature story concerning General Myers', the allegations against Dr. Stanford, and the lawsuit. This program brought the matter to the attention of the Secretary of Defense who immediately ordered an investigation.

The Secretary of the Air Force recommended that the Air Force IG conduct an investigation in response to the Secretary of Defense request, and the Secretary of Defense agreed. In June 1982, after a six-month investigation, Lieutenant General Howard W. Leaf, the Air Force IG, issued a report entitled "Report of Investigation into Management of the Cardiothoracic Surgical Service at Wilford Hall USAF Medical Center in the 1977 Time Frame."

The principal conclusions of the Air Force IG's report are set out (verbatim) below:

> a. General Myers did not totally resolve the questions raised by other doctors of Col. Stanford's surgical abilities. He did have conflicting data from several sources in the May 1977 to September 1977 period. The National Consultant's report resolved the question of Col. Stanford's "competency" in Gen. Myers' mind. However, the management actions Gen. Myers took failed to totally *resolve* the issue in the minds of his staff. Further, the Director of Hospital Services, Executive Committee, and Credentials Committee all failed to take appropriate and sufficient actions. The bulk of witnesses testified they perceived then and today that Gen. Myers did very little to resolve the Col. Stanford matter, and that Gen. Myers should have told Milwaukee (CVSA) about the allegations raised against Col. Stanford. Gen. Myers merely *defused* the situation by a series of management actions and eventually allowing Col. Stanford to go to CVSA for a six month fellowship * * * (Emphasis in original.)
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> b. The normal administrative and management procedures for advanced training were not followed in Col. Stanford's case. An exception to AF regulation and policy was made based solely on Gen. Myers' request. The AF/SG deferred to the Wilford Hall Medical Center Commander in this instance.
>
> c. In summary, the issue of notification [of the Milwaukee surgical association of the concerns raised about Col. Stanford's competence] is complex, and not black or white. The normal fellowship process was not used. There are no legal or professional requirements for notification. The issue was not even addressed by anyone at WHMC, and CVSA made no request for information. Based on a long-standing knowledge of Col. Stanford's record and Ebert's report, Gen. Myers believed that Col. Stanford was more than a capable surgeon, and was motivated, as his commander, to protect him from unsubstantiated allegations. Likewise, Gen. Myers would have been forthright had he been asked, but again he would have been cautious in revealing alleged information, and supportive of Col. Stanford's going to CVSA. The medical community, even today, from our look at it, has differing approaches in the exchange of such information. The DOD is *now* attempting to implement an information exchange policy. In the final analysis, it was a judgment call on the part of Gen. Myers—as a physician, an Air Force officer and commander, not to reveal the information unless asked. In retrospect—five years later—notification would have been a prudent course of action. Had they been notified and assuming that CVSA would have accepted Col. Stanford, the unfortunate incident with Mrs. Green could likely have occurred anyway. This untoward incident did not involve surgical abilities, the subject of allegations against Col.

Stanford, but involved a verification process unrelated to surgical, technical skills. (Emphasis in original.)

d. Established credentials procedures were not followed. There was inappropriate action taken by the Credentials Committee during Col. Stanford's six month TDY absence. No Credentials Committee action was documented when limitations were placed upon him after his return to WHMC.

e. The Air Force medical service practice of allowing AF physicians to spend the majority or all of their careers at WHMC could be a contributory factor to the Col. Stanford problem.

The IG's overall assessment of General Myers' management of the Dr. Stanford incident is excerpted verbatim below from the letter transmitting his investigation report to the Armed Services Committee:

> * * * I am convinced the prior commander, Wilford Hall Medical Center was involved in no criminal wrongdoing. Moreover, although an in-depth analysis of this administrative investigation indicates less than strongest management in some instances, as well as the availability on occasion of alternate and preferable management actions, the choice of procedures used in the circumstances does not equate to general mismanagement in the 1977–78 period.

REPORT OF THE INVESTIGATION BY DR. THEODORE COOPER, CONSULTANT TO THE SECRETARY OF DEFENSE, AND MR. JOSEPH H. SHERICK, ASSISTANT TO THE SECRETARY OF DEFENSE FOR REVIEW AND OVERSIGHT

After release of the Air Force IG's report, the staff of the Office of the Secretary of Defense recommended that the Secretary initiate his own investigation of the matter. The Secretary of Defense directed such an investigation, and asked Dr. Theodore Cooper, a cardiologist with extensive government, academic and private sector experience, and Mr. Joseph Sherick, the (then) Assistant to the Secretary of Defense for Review and Oversight, to "evaluate the actions taken in response to the allegations" made about Dr. Stanford and "to review the Air Force Inspector General report * * *" The Cooper/Sherick report was completed in December 1982.

The Cooper/Sherick report concluded that "there were sufficient reasons to be concerned about Dr. Stanford's performance as a cardiac surgeon during the period 1975 though April 1977 * * *" The report also concluded that "the command structure [at Wilford Hall Medical Center], particularly General Myers, did not adequately fulfill its responsibilities to take appropriate and timely action to resolve the concern about Dr. Stanford." According to the report, "General Myers fell short of meeting these responsibilities" in the following respects (verbatim from the report):

> He was unable to ensure that the mortality and morbidity reviews, as well as the new Credentialling Committee, which could have addressed the situation and protected

the quality of medical care, were in fact effective and utilized.

He did not take any apparent action upon receipt of Dr. Akins' data until Dr. Waller's refusal to anesthetize the pediatric patients.

He did not adequately limit Dr. Stanford's surgery in the face of serious allegations about his performance as a cardiac surgeon.

He did not take adequate and prompt action to resolve the issue after it became a matter of general knowledge.

He did not initiate the objective, multiperson, independent review that the situation called for.

He did not ensure that the evaluator he selected to review Dr. Stanford's performance was properly selected, instructed and informed.

He inappropriately claimed that the results of the evaluation resolved the question of Dr. Stanford's performance.

He did not inform others in the hospital that action was being taken to address the concerns about Dr. Stanford's performance as a cardiac surgeon.

The Cooper/Sherick report was also critical of the conclusions reached by the Air Force IG report. The former report concluded (verbatim):

> The Air Force Inspector General report, entitled "Report of Investigation of Cardiothoracic Surgical Service, Wilford Hall, USAF Medical Center," with its supporting material, was a well-prepared, factual presentation of a generally thorough investigation. However, it is our view that certain portions of the conclusions and recommendations do not follow logically from the facts and testimony contained in the report. The report tilts awkwardly to avoid any criticism of General Myers' action. For example, the report states that General Myers was given Dr. Akins' data in mid to late April 1977, yet it hesitates to judge or even comment on his inaction over the next four to six weeks. This and other distortions are serious flaws in the ability of an otherwise excellent report to resolve this unfortunate episode. They served to delay further efforts to bring this matter to a final and just ending.

Finally, the Cooper/Sherick report noted that, although it examined only the incident at Wilford Hall Medical Center, and the command structure's response, it was also apparent that the failure went beyond the individuals and the institution involved in this episode. The report concluded that, "There was a significant systems failure that permitted the incident to occur and then go unreported, unexamined and uncorrected for so long a time." The report notes that policy changes have been made by the Deputy Secretary of Defense to correct these weaknesses.

Statement Submitted by Maj. Gen. Paul W. Myers

The Armed Services Committee invited General Myers to submit a statement on his management of the allegations against Dr.

Stanford. General Myers was specifically asked to respond to the reports prepared by the Air Force IG and Dr. Cooper and Mr. Sherick.

At the outset of his April 8, 1983 submission to the Committee, General Myers states that he considers the "core question" to be: "Were appropriate and timely actions taken to resolve the issue of Col. (Dr.) William Stanford's alleged surgical incompetence viewed from the time of the event and the then available management options?" He then outlines the management actions which he concludes "seemed prudent, appropriate and logical at the time." In support of this conclusion, General Myers makes the following points:

1. General Myers was unaware of staff concern over Dr. Stanford's surgical performance until late May 1977, when Dr. Akins presented him with his mortality review and Dr. Waller refused to anesthetize one of Dr. Stanford's patients.

2. At that time, General Myers initiated a series of "short-term solutions" to meet three priorities: first, patient protection; second, ensuring that Dr. Stanford had an opportunity to respond to the allegations; and third, gathering further evidence to prove or disprove the allegations.

3. Consistent with these solutions, two pediatric patients requiring cardiac surgery that entailed high risk were transferred to other medical centers. In addition, Dr. Stanford voluntarily limited his adult operating schedule.

4. At the same time, General Myers tried to reconcile the mortality review prepared by Dr. Akins with statistics provided in response by Dr. Stanford. Because the two reviews differed significantly, he requested more definitive data which he did not receive until September 1977. Even then, the data sets remained inconsistent and therefore, inconclusive.

5. In the most significant short-term action, General Myers requested Dr. Paul Ebert, the Air Force National Consultant for Cardiothoracic Surgery, to evaluate the conflicting mortality statistics during his visit to Wilford Hall in September 1977. General Myers believed that a final resolution of the allegations could be safely postponed until September because his other management actions "contained the problem, particularly in regard to patient safety." In General Myers' opinion, Dr. Ebert's report—which was forwarded to the Surgeon General of the Air Force—constituted a "formal review" which clarified the uncertainty surrounding Dr. Stanford's surgical record. General Myers interpreted the Ebert report to conclude that Dr. Stanford's large number of high risk patients justified his mortality rates. The mortality reviews conducted by both Dr. Ebert (in September 1977) and by an Army team of cardiac surgeons are cited by General Myers to disprove the data collected by Dr. Akins.

6. General Myers believes the Milwaukee fellowship that Dr. Stanford accepted was a "mid-term action" for "if Dr. Stanford had any technical or proficiency defects, they would become readily obvious to experienced surgeons who would be watching from across the operating table on a daily basis." General Myers explains that he did not inform the Milwaukee group of the allegations against Dr. Stanford because they were only "allegations", the mortality

statistics conflicted, and Dr. Ebert's assessment "did not call for a notification."

7. Three "long-term actions" completed General Myers' management response to the allegations against Dr. Stanford. First, in November 1977, General Myers requested an assessment of the goals and objectives of the cardiothoracic surgical activity. Second, he conducted a review of reports of Dr. Stanford's performance in Milwaukee. Third, he scheduled a three-month period of observation of Dr. Stanford's surgical practice upon his return to Wilford Hall. General Myers believed that after the completion of his short-, mid-, and long-term actions, "The question of Dr. Stanford's competence, although complicated and time-consuming, had been resolved in my mind.

The conclusion to Major General Myer's letter to the Armed Services Committee includes the following passage (verbatim):

> I can't answer in 1983 questions about timeliness of action, initiative, alternate actions or proper sequence of actions. That would be purely speculative. I can and have looked back, much more frequently than others and asked, "Were there other management choices available." Yes, there were. There were many. Should I have chosen other actions and applied them in a different sequence? In light of what has happened since 1977? I answer that question with an emphatic, "Yes." The most important question to ask is this one. "Would other management actions have provided any greater protection to patients?" The answer to that key question is, "No." Patients were not put at risk from the end of May 1977 through my departure from Wilford Hall in July 1978 when I relinquished command. Would different actions have prevented the tragedy in Milwaukee? I don't believe there is an answer to that question.

Reviews of Dr. Stanford's Mortality Rates

After the Air Force Inspector General initiated his investigation in January 1982, it became apparent that no detailed conclusive review of Dr. Stanford's surgical competence had been conducted. In an effort to finally resolve the questions raised about Dr. Stanford's surgical record at Wilford Hall, two formal mortality reviews have been requested by the Air Force and performed since January 1982. Their conclusions are summarized below.

1. REPORT PREPARED BY ARMY TEAM

On July 19, 1982 the Air Force asked the Army to detail cardiac surgeons to assist the Air Force in a review of Dr. Stanford's mortality record. Colonel (Dr.) Russ Zajtchuk, the Chief of the Thoracic-Cardiovascular Surgery Service at the Walter Reed Army Medical Center, was appointed chief of a team composed of one Air Force and three Army thoracic surgeons (including Dr. Zajtchuk) and a cardiologist employed by the Air Force.

The team compared Dr. Stanford's surgical record from 1969 through May 1980 to the composite record of all other surgeons

who worked at Wilford Hall during the same period of time. In its report of August 1982, the team presented the following major conclusions (verbatim):

> a. Dr. William Stanford was a good, and frequently an excellent surgeon.
>
> b. Previously presented data [Dr. Akins' statistics] was not comprehensive, not objective and was biased.
>
> c. The vast majority of Dr. Stanford's deaths were patients that were of high risk.
>
> d. Mortality data which were previously presented [by Dr. Akins] are incorrect.
>
> e. Mortality and morbidity data [experienced by Dr. Stanford] is not out of line with national standards for the type of cases operated on.
>
> f. Col. William Stanford's mortality was not statistically different from other staff surgeons collectively at Wilford Hall USAF Medical Center in any of the surgical categories except for mitral valve replacement.

The Cooper/Sherick report included the following comments, among others, on the review conducted by the Army team: "The team made a significant contribution by clearly delineating the data bases. It also concluded that Dr. Stanford was a good and frequently an excellent surgeon. However valid that conclusion may be, the methodology of the team can be questioned."

2. REPORT PREPARED BY SOCIETY OF THORACIC SURGEONS

On December 31, 1981, the Air Force requested the Society of Thoracic Surgeons to review Dr. Stanford's surgical cases at Wilford Hall from 1974 through 1977. The Society's Committee on Standards and Ethics assembled a review panel of three thoracic surgeons who prepared a report approved by the Society on April 24, 1983.

The specific questions and answers that the Society sought to determine about Dr. Stanford's surgical performance are presented (verbatim) below:

> a. *Were the surgical cases "high risk" cases?* Of the 173 open heart cases evaluated, 71 or 41 percent were "high risk" cases in the judgment of the Committee [the Society's Committee on Standards and Ethics].
>
> b. (Not applicable.)
>
> c. *What was the mortality rate for these surgical cases?* The mortality rate for the 173 open heart cases was 35/173 or 20.2 percent. The mortality rate for the other reviewed cases was 18/117 or 15.4 percent.
>
> d. *Whether the mortality rate as determined was acceptable?* The mortality rate was acceptable in the areas of non-cardiac thoracic surgery and in cardiovascular surgery in the areas of aortic valve surgery, coronary artery surgery, extra cardiac congenital cardiovascular surgery and simple congenital intracardiac surgery.
>
> The mortality rate in the period reviewed appears questionable compared to nationally published data from the

time period in question in mitral valve surgery, multiple valve surgery, coronary artery surgery plus other procedure(s) and complex congenital intracardiac surgery. However, the number of patients in each of these categories is so small that statistical validity studies were not applied.

e. *Such other conclusions concerning Dr. Stanford's performance as the Committee deems appropriate.* Dr. Stanford's results in pulmonary, esophageal and other non-cardiac surgery were judged to have been good. He handled difficult cases with acceptable results. His results in cardiovascular surgery were acceptable in the areas of aortic valve surgery, extra cardiac congenital cardiovascular surgery, and simple congenital intracardiac surgery.

Dr. Stanford's results in mitral valve surgery, multiple valve surgery, uncomplicated coronary artery surgery, coronary artery surgery plus other procedure(s), and complex congenital intracardiac surgery in the period reviewed appear questionable. Statistical validity studies were not applied because of the small number of cases.

The type of operation selected in some of the complex congenital intracardiac cases was judged to have been questionable.

Despite acceptable mortality rate, Dr. Stanford's results in uncomplicated coronary artery surgery appear questionable, because 18 out of 37 cases restudied before discharge had graft occlusion.

Committee Findings

After reviewing General Myers' career, including the incidents at Wilford Hall concerning Dr. Stanford, the Committee makes the following findings:

1. General Paul Myers has served as a physician in the Air Force since 1949. The information available to the Committee indicates that his military career as a neurosurgeon has generally been outstanding. Dr. Myers rose through the ranks of the Air Force to become the Commander of that Service's major hospital, the Wilford Hall Medical Center in San Antonio, Texas. From this assignment, he was appointed Surgeon General of the Air Force, a position in which he served from 1978 to 1982. As Surgeon General, he improved the readiness of military personnel, expanded training programs, and improved medical facilities. He worked to improve the retention of trained, qualified and dedicated medical personnel.

2. Concerning the incidents at Wilford Hall from 1975 through 1977 the Committee believes in general that General Myers and others within the Air Force medical community did not utilize the best available management procedures to investigate and resolve the allegations concerning Dr. Stanford's surgical performance. In this particular instance, there was a failure of the Air Force health care management system.

3. More specifically, the Committee believes:

a. There were sufficient reasons to be concerned about Dr. Stanford's performance as a cardiac surgeon at Wilford Hall

during the period from 1975 to 1977. The allegations made about Dr. Stanford's competence, first by Doctors Akins and Waller in April and May 1977, and subsequently by other members of the medical staff, raised serious and potentially deterimental implications for patient care and human life. These allegations should have been investigated promptly and thoroughly and conclusively resolved.

b. General Myers, as Commander of Wilford Hall, was primarily responsible for resolving the allegations raised concerning Dr. Stanford. The Committee is aware that General Myers took certain steps when confronted with these allegations to protect patients and to resolve the matter. As the reports of the Air Force Inspector General and of Dr. Cooper and Mr. Sherick indicate, there is a difference of opinion as to whether the steps taken by General Myers were sufficiently thorough and prompt. The Committee concludes that those steps did not meet this criteria. Stronger management actions were available and necessary, and should have been used.

c. While General Myers had the primary duty to act on the allegations against Dr. Stanford, the Committee concludes that others, both at Wilford Hall and in the senior leadership of the Air Force in the chain of command above General Myers, did not fully meet their responsibilities for dealing with these allegations in a thorough, expeditious and objective fashion.

4. The Committee believes that General Myers should have apprised Cardiovascular Surgery Associates, the private surgical association in Milwaukee, that questions had been raised concerning Dr. Stanford's surgical performance. No regulations at that time required such notification, and Cardiovascular Surgery Associates did not request any details about Dr. Stanford's record. However, the serious nature of the allegations made by Dr. Stanford's peers at Wilford Hall—allegations still unresolved at the time Dr. Stanford went to Milwaukee—should have led General Myers to alert Cardiovascular Surgery Associates.

5. The Committee believes that the brief and benign conclusions and recommendations of the Air Force IG fail to reflect all the facts concerning General Myers' conduct set forth in the Air Force IG's own report. This apparent inconsistency raises serious concerns about the objectivity of this investigation of a high ranking Air Force officer. The Committee intends to exercise vigorous oversight of the Military Services' Inspector General systems in the future to ensure that they function competently, fairly, and objectively.

6. The Committee is encouraged by the actions taken by the Defense Department, including the Air Force, to correct the weaknesses in the Military Services' health care delivery systems identified as a result of the incidents at Wilford Hall. The Departments' recent initiatives in the areas of quality assurance, peer review, and credentialing and referral of medical professionals will strengthen medical care delivery in all of the Military Services.

COMMITTEE RECOMMENDATION

While it has been recognized that there were stronger management actions available to General Myers in handling the allegations with respect to Dr. Stanford, the Committee believes that General Myers' outstanding military career warrants retirement in the grade of Lieutenant General. Accordingly, the Committee recommends that General Myers' nomination to be retired in that grade be confirmed.

This recommendation was approved at a meeting of the full Committee on November 2, 1983 by a recorded vote of 12 yeas and 4 present, with 2 members not voting.

Voting in favor: Senators Tower, Thurmond, Goldwater, Warner, Humphrey, Cohen, Jepsen, Quayle, East, Wilson, Evans, and Stennis.

Voting present: Senators Nunn, Exon, Levin, and Bingaman.

Not voting: Senators Hart and Kennedy.

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